

LEDFORD CHIROPRACTIC, P.C.
CALHOUN, GA 30701
706-602-9696

NEW PATIENT INTRODUCTION TO OFFICE

Patient Name: _____ Date: _____
Medical Doctor: _____ Office Name: _____
Patient Sex: ___M___ F Patient Age: _____ Date of Birth: _____ SS# _____
Patient Address: _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
Insurance Co.: _____ Person Insured: _____
Subscriber employer: _____ Relationship: _____
Who may we thank for referring you? _____
Emergency Contact: _____ Phone Number: _____

COMPLAINT HISTORY

1. Describe your current complaint in the best detail as possible. _____

2. How long have you had this condition? _____ Date of onset: _____
3. Are you aware of what caused the injury or condition, if so what? _____
4. How would you describe the pain? ___ Sharp ___ soreness ___ throbbing ___ tingling ___ dull ___ stiffness ___ spasm
___ Burning ___ ache ___ weakness ___ numbness ___ shooting ___ constant ___ comes and goes ___ extreme (check all that apply)
5. How would you rate the intensity of your pain? (Circle the most appropriate number)
0 1 2 3 4 5 6 7 8 9 10
(No pain) (Moderate pain) (Terrible/ unbearable pain)
6. How often is the pain present?
___ Constant (81-100%) ___ frequent (51-80%) ___ occasional (26-50%) ___ intermittent (25% or less of the time)
7. Since your problem began is the pain:
___ Getting worse ___ getting better ___ staying the same
8. How did your problem begin? ___ Auto accident ___ work accident ___ gradual onset ___ sudden onset ___ no specific reason
___ Other accident or injury—Explain _____
9. What makes your problem better? _____
10. What makes your problem worse? _____
11. Are you currently taking any medications? If yes please describe. _____
12. Have you been previously treated for this condition, if yes by whom and the results? _____

13. What is your physical activity at work? ___ Mostly sitting ___ light labor ___ moderate labor ___ heavy labor
Please describe: _____

SOCIAL HISTORY

1. Do you smoke? ___ Yes ___ no, If so how much per day? _____

2. Do you drink alcohol? ___ Yes ___ no, If so how much per day, per week? _____
3. Do you have any history of cancer or tumors? If so please describe in detail. _____
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4. How is your sleep? ___ Poor ___ average ___ excessive
5. Does your pain ever wake your from sleeping? ___ Yes ___ no, if so how often? _____
6. When is your pain the worst? ___ Morning (rising from sleep) ___ mid -day ___ evening ___ night (while in bed)

WOMEN ONLY: MENSTRUAL HISTORY

1. Date of onset of last period _____. Age of onset of menstrual cycles ____ Are they regular ___ yes ___ no
If not explain. _____
2. Are you currently pregnant? ___ Yes ___ no are your currently using birth control? ___ Yes ___ no what? _____

FAMILY HEALTH HISTORY

	SELF	FATHER	MOTHER	BROTHER (S)	SISTER (S)	SPOUSE	CHILDREN
ARTHRITIS							
ASTHMA							
BACK PAIN							
BURSITIS							
CANCER							
DIABETES							
Disc Problem							
EMPHYSEMA							
EPILEPSY							
HEADACHES							
Heart trouble							
High blood pres							
INSOMNIA							
KIDNEY DX							
MIGRAINES							
NERVOUSNESS							
SCOLIOSIS							
Sinus Trouble							
Stomach Trouble							
Other							

I certify that all information given is accurate to the best of my knowledge. I understand all questions asked and the answers given; I understand that given incorrect information can be dangerous to my health. I authorize the chiropractor to perform any test or procedures necessary to determine the care I may need. I also authorize the chiropractor to treat me with usual and customary means to his technique. I also understand I am responsible for all bills incurred due to my care, regardless of any arrangement with my insurance company.

Signature of Patient (or parent of a minor)

Date